Go to Back Page | Print | Reset

APPLICATION FOR MEDIATION OR HEARING – FORM B

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

☐ **I hereby certify that we have complied with Rules 1301 through 1305 and Parts 9 and 10 of the Workers' Compensation Health Care Services Rules**

Submitted on behalf of: ☐ Health Care Provider ☐ Insurance Company ☐ Self-Insured Employer

EMPLOYEE IDENTIFICATION

1. Employee Name (Last, First, MI)		2. Social Security Number	3. Date of Birth	4. Date of Injury
5. Street Address	6. City	7. State	8. ZIP Code	9. County of Injury

EMPLOYER IDENTIFICATION

10. Employer Name		11. Federal I.D. Number	
12. Street Address	13. City	14. State	15. ZIP Code
16. Contact Person		17. Telephone Number	

CARRIER IDENTIFICATION

18. Carrier or Self-Insured Name		19. NAIC or Self-Insured Number	
20. Street Address	21. City	22. State	23. ZIP Code
24. Claim Handler	25. Claim Number	26. Telephone Number	

HEALTH CARE PROVIDER IDENTIFICATION

27. Provider Name		28. License, Registration, or Certification Number	
29. Street Address	30. City	31. State	32. ZIP Code

33. Date of Service	Amount of Bill	Date of 1st Billing	Date of 2nd Billing	Late Fee Requested	Reason for Filing (see codes on reverse)

34. ☐ If the worker involved in this case is currently being denied treatment as a result of this dispute, check the box on the left and provide a description of the needed treatment that is being denied in the box on the back.

35. ☐ If the carrier is currently paying for medical benefits pursuant to an order and this is a petition to stop such payment, check the box on the left and attach a copy of the order.

By signing this form, I certify that the information included on this form is true, correct and complete to the best of my knowledge. I understand that making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

36. Applicant Name	37. Applicant Signature	38. Applicant Telephone Number	39. Date
40. Name of Attorney (if applicable)	41. Attorney I.D.	42. Attorney Signature	

Reason for Filing Codes (last column in Line 33)

A. No response to the bill
B. Not paid in 30 days per R418.10116 (2)
C. No carrier response to provider's request for reconsideration
D. Incorrect payment, not resolved by provider's request for reconsideration
E. Claim in litigation, medical services remain unpaid
F. Carrier disputed utilization of medical services
G. Carrier requests recovery of payment
H. No report of injury on file with carrier
I. Other

Additional information regarding Reason for Filing:

This form is only to be submitted in cases involving workers' compensation health care disputes between carriers (insurance companies, self-insured employers, or group funds) and health care providers.

The completed application must be mailed to the Workers' Compensation Agency, PO Box 30016, Lansing, MI 48909, with a completed copy mailed to the carrier. **There is no need to send additional documentation to have the teleconference scheduled.**

You must complete this form properly to avoid any delay in processing.

All parties involved in this case will be served a copy of the Form 104B and a teleconference will be scheduled. You can obtain more information or forms by contacting the Workers' Compensation Agency at 1-888-396-5041.

This application is provided in accordance with Part 13, R 418.101303 of the Workers' Compensation Health Care Services Rules.

Go to Front Page